WEST VIRGINIA INTEGRATED BEHAVIORAL HEALTH CONFERENCE

MOTIVATIONAL INTERVIEWING

Engaging People into Treatment and Change

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Treatment Engagement

- Attendance
  - Entering, staying in, and completing
  - Attending consistently
- Participation
  - In-session procedures
  - Between-session activities

Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - Measured dropout by 3 months from 8 residential (modified therapeutic community) drug and alcohol treatment programs run by the Australian Salvation Army (N = 618)
    - 10 month program

Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - 57.3% dropped out by 3 months
    - 3 months is widely viewed as the minimum length of treatment sufficient to result in significant improvements (e.g., Simpson, 1979)
  - This is at the low end of the range for dropout from long-term programs
    - 50 – 80%

Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - Why? Looked at 11 possible client factors
    - Age, Gender, Primary substance used, Criminal involvement, Alcohol or drug cravings, Symptom distress, Self-efficacy to abstain, Spirituality, Forgiveness of self, Forgiveness of others, Life purpose
  - All of these <u>together</u> explained only 9.5% of the variance in dropout

Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - Why were they surprised?
    - "Finding reliable predictors of dropout and retention in drug treatment has proven difficult in prior settings... Numerous other empirical studies have found few client-related predictors, and, of these, the amount of variance explained has been moderate at best... Furthermore, individual predictors have generally been found to be inconsistent across studies..."

Engagement in Alcohol & Drug Treatment

- Looking for the reasons for failure to engage and adhere to treatment in client characteristics is not the answer

Why would the people NOT be motivated to engage in treatment?

They're not ready to change

Why would people NOT be motivated to change?

Against Change

- Change is scary (the familiar feels safe)
- Loss of sources of pleasure/satisfaction
- Reluctance to give up current ways of coping
- Effects on lifestyle and other priorities
- Effects on social connections / relationships
- Painful self-recognitions (guilt and shame)
- Threat to sense of self
- Uncertainty of success (expecting failure)

Why would people NOT be motivated to engage in treatment?

It's not just about readiness to change

Influences on Engagement

- Practical Barriers
  - Finances
  - Access
  - Conflicting Obligations
  - Safety
- Symptom Barriers
  - Vegetative
  - Affective
  - Cognitive
- Functional Barriers
  - Life in chaos
  - Demands of the substance

Influences on Engagement

- Treatment & Provider Characteristics
  - Intensity
  - Modality
- System Factors
  - Provider overload
  - Service fragmentation
- Negative Treatment Expectancies
  - Efficacy
  - Aversiveness
- Negative Experiences
  - Personal
  - Vicarious

Influences on Engagement

- Help-Seeking Attitudes
  - Privacy vs. Self-disclosure
  - Self-reliance vs. Dependency
  - Care-giving vs. Self-care
- Relationship Expectancies
  - Authoritarian/Controlling vs. Authoritative/Guiding
  - Exploitative/Intrusive vs. Respectful/Supportive
  - Incompetent/Uncaring vs. Nurturant/Involved

Influences on Engagement

- Cultural Barriers
  - Stigma
  - Community preferences
  - Client / Clinician differences
    - Race
    - Religion
    - Ethnicity
    - Gender
    - Age
    - Class

Cultural Barriers

- *Sitting in front of a white therapist isn't necessarily like she thinks she is better than me… but there are some white people who think they can look down on you and show favoritism to people of their nature and culture and treat you any kind of way.*
- *I thought you were going to be a woman.*

Motivation for Change ≠ Motivation for Treatment

- Readiness to change has a large impact on readiness to engage in treatment
- Readiness to change is not sufficient for engagement in treatment
- The focus of intervention to increase engagement is motivation for treatment

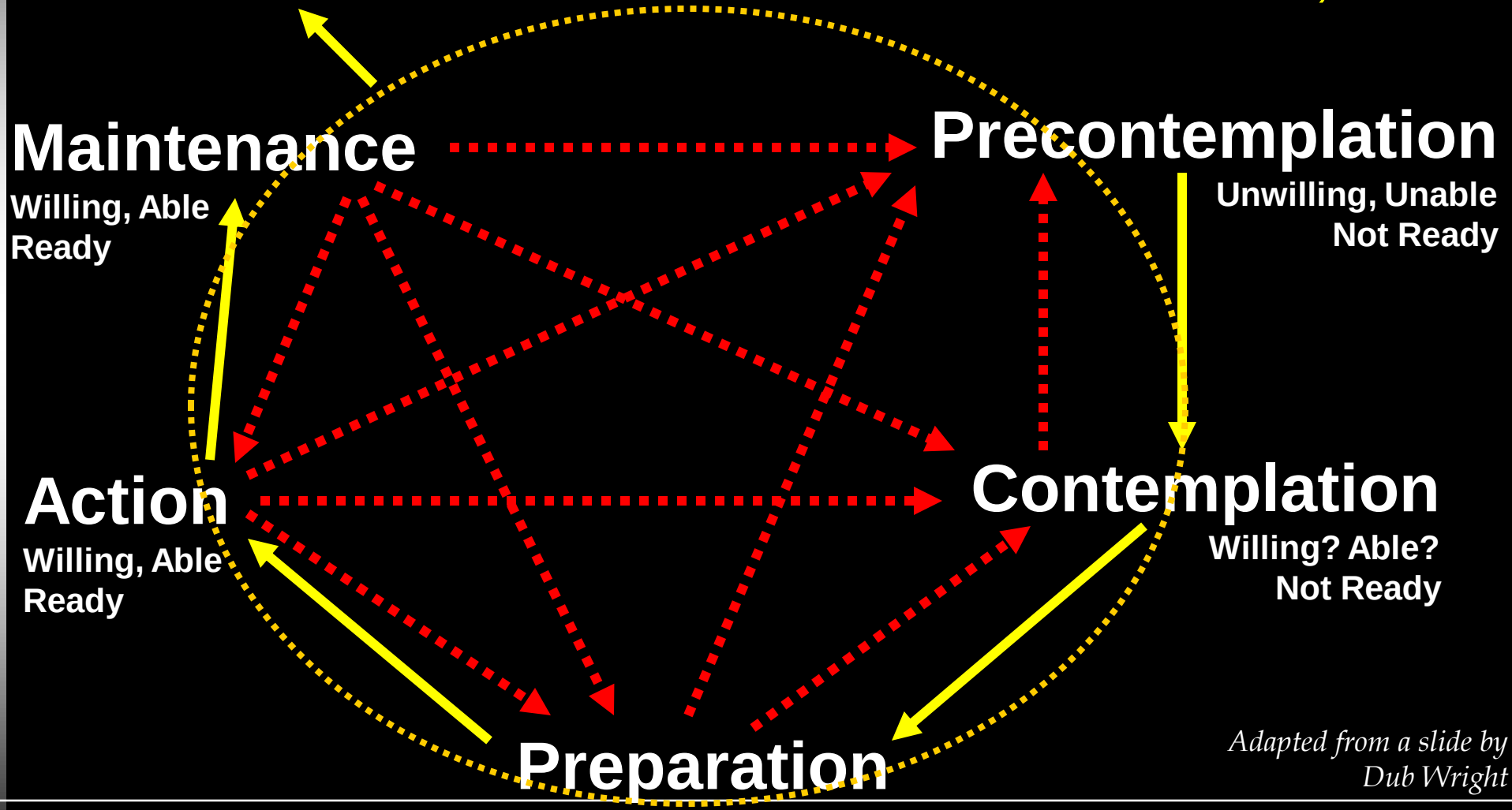
When Are People Motivated To Change or Engage?

"Ready, Willing, & Able"

- Importance
  - Recognition of Problem / Need
  - Cost / Benefit Expectancies
    - Values
- Confidence
  - Specific Behavior
  - Global Efficacy
- Commitment
  - Intention

Stages of Change

Prochaska & DiClemente, 1992



Adapted from a slide by Dub Wright

Talking about Change
Precontemplative

- Don't see a problem, believe the benefits of change outweigh the costs, or believe they can change
- Five R's (Adapted from DiClemente, 1991)
  - Reluctant
  - Rebellious
  - Rationalizing
  - Resigned
  - Receptive/Deceptive

How Many Of You Have Ever…?

Talking about Change
Contemplative

- Facing a decision about change, people consider and contemplate their options

Ambivalence Under Pressure

- Six R's
  - Reluctant
  - Rebellious
  - Rationalizing
  - Resigned
  - Receptive/Deceptive
  - Relieved

Ambivalence

- Facing a decision about change, people contemplate their options
- People get stuck in ambivalence when
  - they don't know what they want to do (conflicting options have advantages/disadvantages)

    and/or
  - they don't believe they can do what they want to do (succeed at accomplishing a desired choice)

The Righting Reflex

- Urge to set things right
  - Desire to fix
    - Advice, education, persuasion, direction, confrontation
- Clinician as expert
  - Clinician knows what, why, and how
  - Client is ignorant and faulty and needs direction
- Triggers reactance in those who are ambivalent
  - Protection of freedom by defending autonomy and resisting control

Rethinking Resistance

- Ambivalence under pressure
  - Discord
    - Tension or defensiveness in the relationship, in response to negative judgment and/or control
      - Interpersonal
    - Can be anticipatory or triggered by the clinician
      - Protection of self-esteem or autonomy

Recognizing Discord

- Arguing
  - Challenging
  - Hostility
- Ignoring
  - Inattention
  - Nonanswer
  - No Response
  - Sidetracking
- Interrupting
  - Talking Over
  - Cutting Off
- Discounting/Negating
  - Blaming
  - Excusing
  - Claiming Impunity
  - Minimizing
  - Denying
- Pseudocompliance
  - Blanket agreement
  - Passivity

Ambivalence, Motivation, Change

- It's normal (though unpleasant and undesirable) for people to get stuck in ambivalence
- Motivation for change and treatment is influenced by interpersonal interactions
- Interpersonal pressure (unsolicited advice or information, persuasion, direction, confrontation) makes ambivalent people sound and feel "resistant"

Ambivalence, Motivation, Change

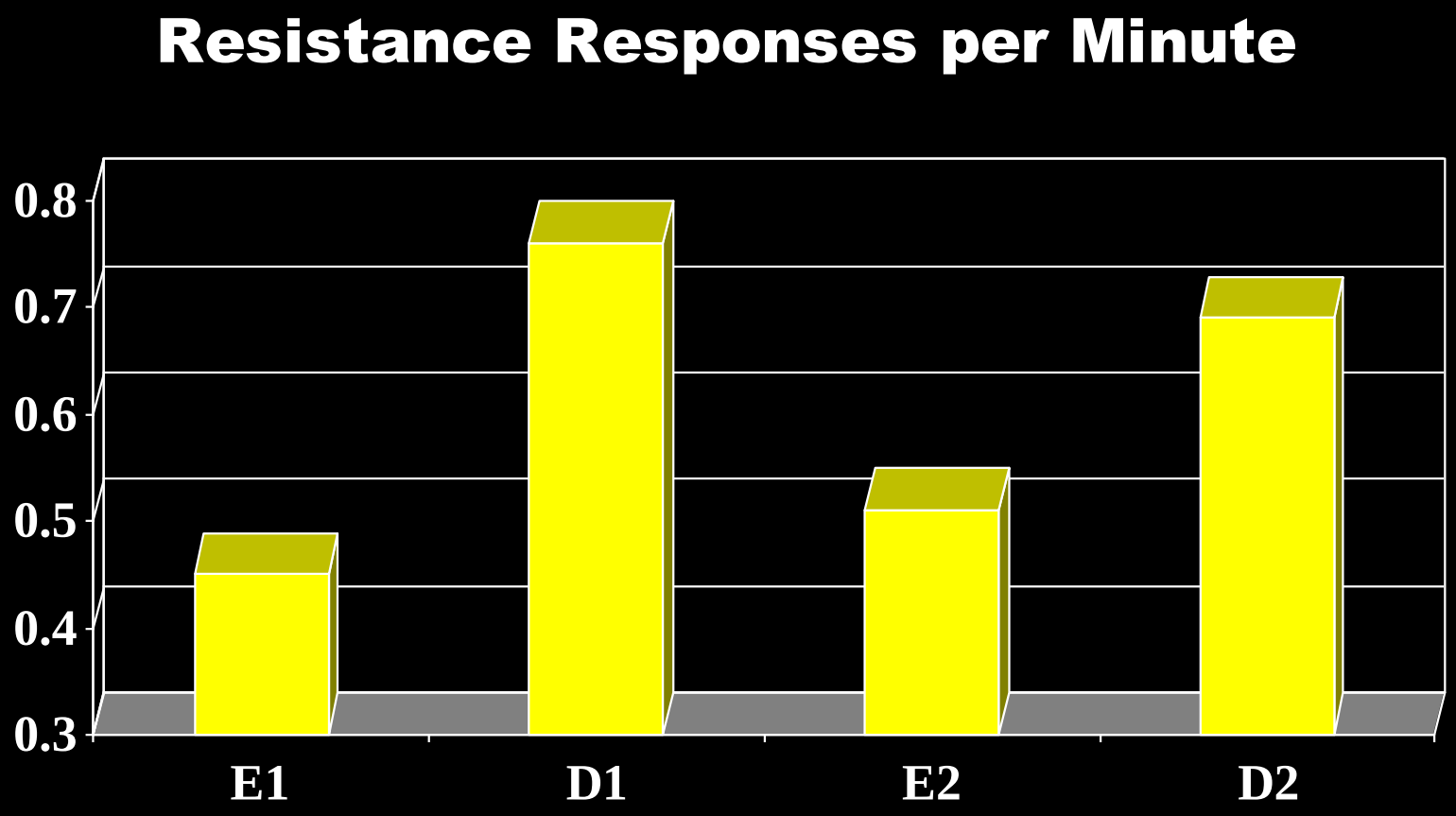
- "Resistance" tends to elicit unhelpful reactions from clinicians
- "Resistance," therefore, is not a client problem—it is a clinician problem
- Understanding ambivalence is the first step toward helping clients resolve it

Resistance & Therapist Behavior

Patterson & Forgatch, 1985, 2001

- Family Therapy Studies
  - 12 families with aggressive children 3.8 – 13.1 y.o.
  - Coding systems for therapist and client behavior
- Results
  - Observation of videotaped sessions
    - "Teach" & "confront": increased resistance
    - "Facilitate" & "support": decreased resistance
  - Manipulation (ABAB) of "teach" & "confront"
    - Changes in therapist behaviors: increases in resistance

Patterson & Forgatch, 1985



Resistance and Change

- Drinker's Check-Up: Confrontational Feedback vs. Client-centered Feedback (Miller et al, 1993)
  - More confrontation = More drinking at 1 year
  - More confrontation = More patient resistance
  - More resistance = More drinking at 1 year
- Project MATCH (Karno & Longabaugh, 2005)
  - High-reactance patients: directiveness (interpret, confront, introduce topics) = worse outcomes

If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?

The Pressure Paradox

Acceptance facilitates change;

Pressure to change elicits resistance to change

If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?

The Relational Component of MI

Understanding and learning from the client

The Relational Component of MI

- Compassion
  - Focus on the needs of the other
    - Openness to and concern for suffering
    - Wish to relieve suffering and promote well-being
  - Founded on a sense of shared humanity
    - We are courageous in making choices without knowing with certainty ahead of time whether or not things will turn out right
    - We are all fallible and flawed, bound to make mistakes and despite our good intentions

The Relational Component of MI

- Acceptance
  - Absolute Worth
    - Tendency for growth toward a positive *telos*
    - Deep and nonjudgmental valuing for who they are, as they are
  - Affirmation
    - Unconditional positive regard / Prizing
    - Attunement to strengths and positive intentions

The Relational Component of MI

- Acceptance
  - Autonomy Support
    - Honoring and supporting the right and capacity for self-determination
    - Recognition of personal responsibility for change
  - Accurate Empathy
    - Communicating understanding of thoughts and feelings without judgment

The Relational Component of MI

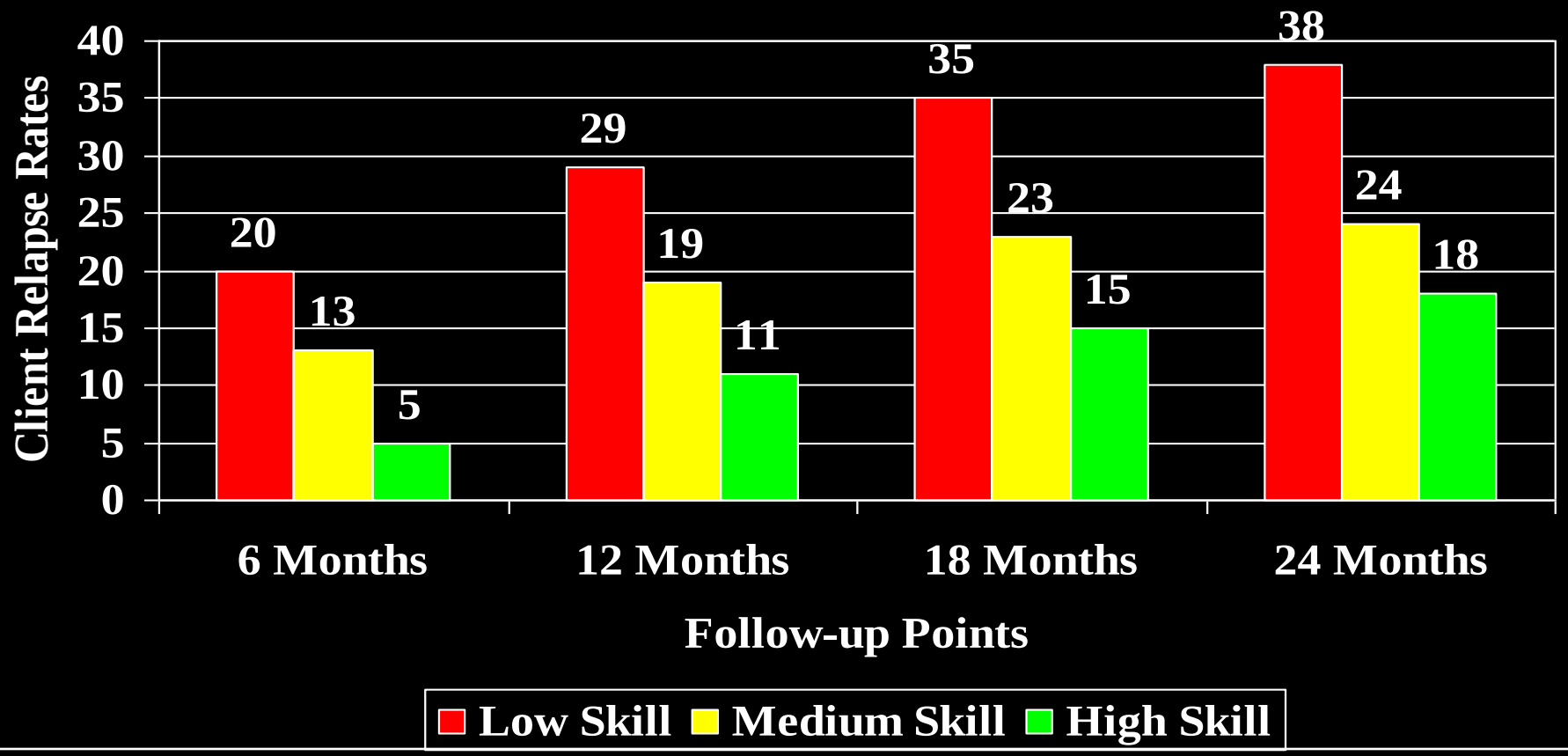
- Partnership
  - Change is most likely where the aspirations of clients and clinicians meet
  - Both members of the relationship have unique expertise that can be contribute to the facilitation of change

Research Support for the Relational Component

Alcohol Treatment

- Miller, Taylor, & West (1980)
  - Empathy strongest predictor of outcome in differing behavioral treatments for problem drinkers
- Valle (1981)
  - Client-centered skillfulness predicted long-term sobriety following inpatient rehabilitation

Valle, 1981


Client Relapse Rates
40
35
30
25
20
15
10
5
0
20
13
5
29
19
11
35
23
15
38
24
18
6 Months
12 Months
18 Months
24 Months
Follow-up Points
Low Skill
Medium Skill
High Skill

Research Support for the Relational Component

Counseling and Psychotherapy

- Empathy
  - Medium-sized effect across psychotherapies (Elliott, Bohart, Watson, & Greenberg, 2011)
- Collaboration / Goal Consensus
  - Medium-sized effect across psychotherapies (Tryon & Winograd, 2011)
- Affirmation / Positive Regard
  - Medium-sized effect across psychotherapies (Farber & Doolin, 2011)

Research Support for the Relational Component

Medical Settings

- Zolnierek & DiMatteo, 2009
  - Meta-analysis of 106 correlational studies found a 19% higher risk of non-adherence among patients of physicians who communicate poorly
- Hojat, et al., 2011
  - Patients of physicians with high empathy scores were significantly more likely to have good control of HbA1c and LDL-C than physicians with low empathy scores

If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?

The Motivational Component of MI

We learn what we think
as we hear ourselves speak

Not the clinician, but the client, argues for change

Change Talk

- DARN (Preparatory)
  - Desire — *I want to…*
  - Ability — *I can…*
  - Reasons — *I should because…*
  - Need — *I have to…*
- CATs (Mobilizing)
  - Commitment — *I might… → I'll try… → I will…*
  - Activation — *I'm ready to…*
  - Taking steps — *I've begun to…*

Rethinking Resistance

- Ambivalence under pressure
  - Sustain Talk
    - The other side of the decisional balance
      - Motivation to stay the same
    - Normal and expectable when someone is ambivalent
      - More frequent and insistent when the clinician is ahead of the client's readiness to change

Sustain Talk

The Other Side of Ambivalence

- I like getting high.
- I don't see how I could stop drinking.
- Skipping med doses saves me money.
- I need to stay away from meetings.
- I'm going to hang with the people I like.
- I'm not ready to give up my lifestyle.
- I told my therapist I'm not coming back.

The Motivational Component of MI

- Evocation
  - Drawing out and strengthening motivation for change already present, if dormant
  - From "I have what you need and I'm going to give it to you" to "You have what you need and together we will find it"
  - Clinician as midwife

Research on Change Talk

- Training in MI is associated with stronger change talk in clients[2]
- MI-consistent behaviors increase probability of patient change talk[3,4]
- MI-inconsistent behaviors increase probability of patient counter-change talk[3,4]

[1] Amrhein et al., 2003 [2] Amrhein et al., 2004 [3] Moyers & Martin, 2006 [4] Moyers et al., 2009 [5] Hodgins et al., 2009

Research on Change Talk

- Preparatory talk → commitment talk[1,5]
- Increasing intensity of commitment talk → change[1,5]
- Change talk → change, sustain talk → no change[4]

[1] Amrhein et al., 2003 [2] Amrhein et al., 2004 [3] Moyers & Martin, 2006 [4] Moyers et al., 2009 [5] Hodgins et al., 2009

Motivational Interviewing

- Collaborative conversation for strengthening a person's own motivation and commitment to change
  - Evokes movement toward a goal by partnering with people to elicit and explore their own reasons and ability for change within an atmosphere of acceptance and compassion

The Spirit of MI

- Compassion
- Acceptance
  - Absolute Worth
  - Affirmation
  - Autonomy Support
  - Accurate Empathy
- Partnership
- Evocation

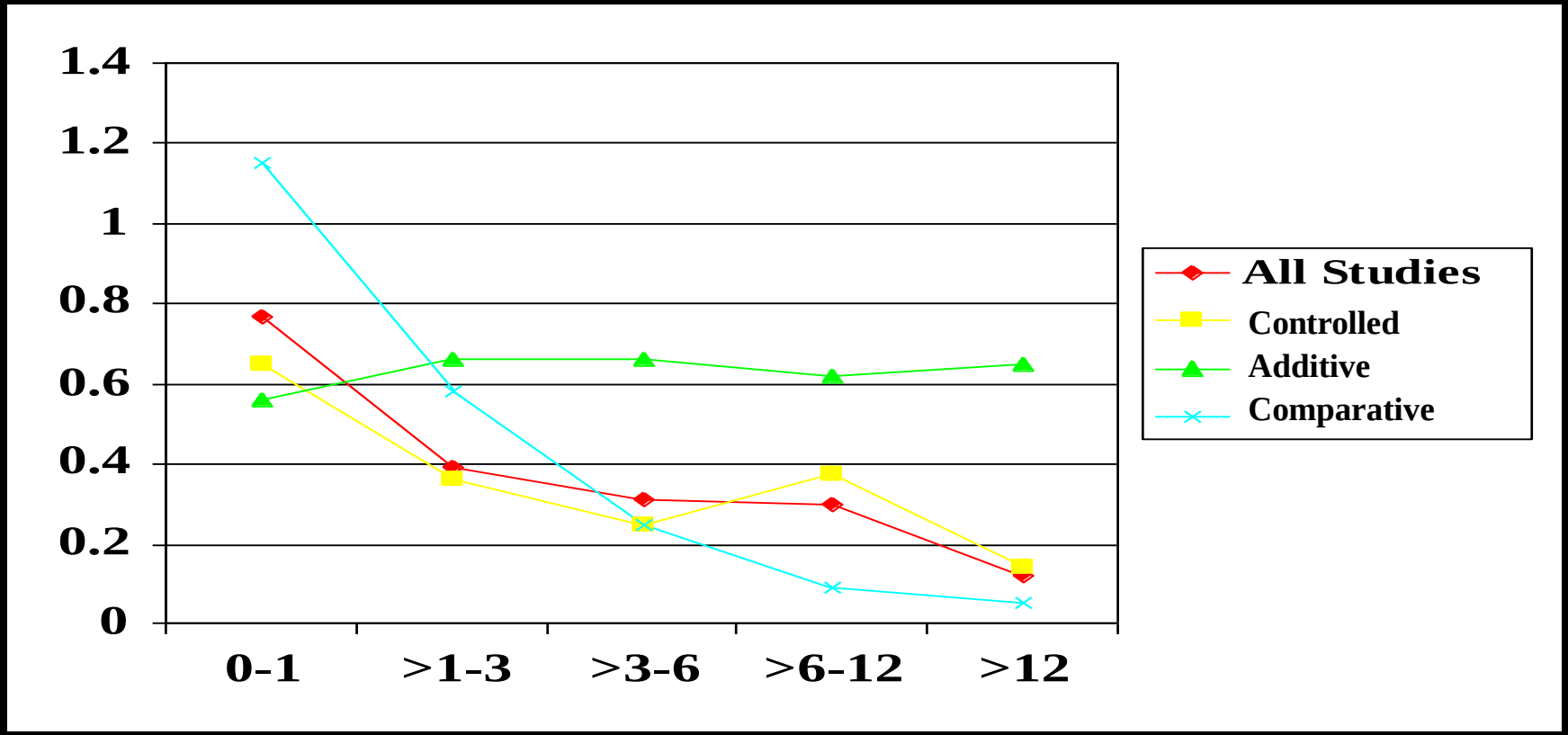
Evidence for MI for Engagement

Zuckoff & Hettema, 2007, November

- Meta-analysis of controlled trials of MI for treatment adherence (N = 29)
  - d_c = 0.48 (medium size effect)
    - Alcohol and/or drug (21), psychiatric (3), diet and exercise (2), smoking (1), pain (1), sleep apnea (1)
    - MI sessions = 3.14 (5.20); hours spent in MI =2.46 (3.53)

Hettema, Steele, & Miller, 2005

Effect Sizes of MI over Time



Four Processes in MI